Statement of Changes and Reasons
Chapters 41, 44, 45, and 46

Chapter 41

The Wyoming Department of Health is repealing Chapter 41 because the program has expired and federal financial participation no longer exists. The services available under this waiver have been replaced by the services available under Chapter 46 described below.

Chapter 44

Rules and Regulations for Environmental Modifications, Specialized Equipment, and Self-Directed Goods and Services for Medicaid Home and Community Based Waiver Services

The Wyoming Department of Health is filing rules pursuant to the statutory authority in Wyoming Statute §§ 9-2-102, 42-4-104, 42-4-120, the 2013 Wyoming Session Laws page no. 322 through 325, and the Wyoming Administrative Procedures Act found at §§ 16-3-101 through 16-3-115. Chapter 44, Wyoming Medicaid Rules for Environmental Modifications, Specialized Equipment, and Self-Directed Goods and Services for Medicaid Home and Community Based Waiver Services was amended primarily to include Self-Directed Goods and Services for Medicaid Home and Community Based Waiver Services.

Strike and Underline revisions were applied to document all amendments to Chapter 44. These changes include minor revisions to improve ease of understanding and general readability throughout the Chapter. The large substantive changes, and reasons for the changes, are described below:

- Chapter 44, Section 4. Definitions were removed from Chapter 44 and can be referenced under the master listed documented in Chapter 1. The Chapter 1 consolidated list reduces the effort required to maintain duplicate definitions in multiple locations.
- Chapter 44, Section 6(j). The Department added additional language to include specific requirements for relatives providing service
- Chapter 44, Section 6(k). The Department added provider certification standards for Environmental Modification providers.
- Chapter 44, Section 7(c). The specialized equipment rules were amended to reflect broader categories of allowances as opposed to a specific list of eligible equipment.
- Chapter 44, Section 9. Self-Directed Goods and Services is a new section added to Chapter 44. Section 9 captures requirements for services, equipment, and supplies and also outlines what is included for Goods and Services under the rule.
- Chapter 44, Section 10. Self-Directed Goods and Services, Limits on the Amount, Frequency, or Duration is a new section. Section 10 was created to document rules

specific to annual financial limits, prior authorization, approval criteria, residence modifications, and financial management service documentation verification.

- The term "case manager" has replaced "individually selected service coordinator" throughout Chapter 44 to better describe the role.

Chapter 45

Rules and Regulations for Waiver Provider Certification and Sanctions

Statutory authority for the adoption and revision of Chapter 45, Wyoming Medicaid Rules and Regulations for Waiver Provider Certification and Sanctions, is in Wyoming Statute §§ 9-2-102, 42-4-104, 42-4-120, the 2013 Wyoming Session Laws page no. 322 through 325, and the Wyoming Administrative Procedures Act found at §§ 16-3-101 through 16-3-115. The rules of Chapter 45 govern certification of providers under the Wyoming Medicaid Adult Developmental Disabilities Home and Community Based Waiver, the Wyoming Children's Developmental Disabilities Home and Community Based Waiver, and the Supports and Comprehensive Waivers. Chapter 45 also applies to the Wyoming Acquired Brain Injury Home and Community Based Waiver.

Many of these revisions are due to the development of the new Supports Waiver and Comprehensive Waiver contained in Chapter 46. In March 2013, the Wyoming Legislature passed Senate Enrolled Act 82, a law requiring Wyoming Department of Health, Behavioral Health Division (BHD) to develop two new waivers, the Supports Waiver and the Comprehensive Waiver. The new law required BHD to "optimize the services provided to current clients, and to extend appropriate services to persons currently on a waiting list for waiver services within the current budget." In 2014 the Wyoming Legislature also created Wyoming Statute § 42-4-103(c), which established parameters for case management services under this program. The provisions of this rule implement these requirements.

Additional changes contained in this rule are part of the State's response to changes in federal Medicaid law. On January 16, 2014, the Centers for Medicare and Medicaid Services promulgated a final rule which requires states to make several changes to new and established services. The Department received guidance from the Centers for Medicare and Medicaid Services that some of these changes, such as the use of conflict-free case management, must be implemented immediately. 42 C.F.R. § 441.301(c)(1)(vi). Additionally, many of these changes must be in place before the Centers for Medicare and Medicaid Services will approve any new waivers in the State. 42 C.F.R. § 441.301(c)(6). Accordingly, this chapter includes modifications to existing programs that are necessary for Wyoming to continue to receive federal financial participation for the Home and Community Based Medicaid Waiver programs affected by this chapter.

These changes are pervasive and the creation of a strike and underscore copy of the rule is impractical. Therefore, a strike and underscore revision of this Chapter is not included with

this packet. The large substantive changes, deletions and additions are described more fully below.

****** References to the current rule refer to the, December 29, 2006, rule which is in effect as of the date of this statement of reasons. References to the new rule refer to changes made in this promulgation.***

The following provisions were deleted in their entirity from the current rule:

- Chapter 45, Section 3(b), of the current rule this section is no longer necessary.
- Chapter 45, Section 4 of the current rule. Relevant definitions for this chapter are currently located in Chapter 1, Section 3.
- Chapter 45, Section 5 of the current rule. provisions for protecting participants receiving Home and Community Based Waiver services are in Sections 4 and 5 of the new rule.
- Chapter 45, Section 6 of the current rule, this section was deemed superfluous and is no longer necessary.
- Chapter 45, Sections 38 through 47 are deleted, these sections are covered in other Wyoming Medicaid rules.

The following provisions reflect moves and changes between the current and new rule:

- Chapter 45, Section 7, Case Management Services, is now located in Section 9 of the new rule. The existing provisions of Section 7(a) through (i) are deleted because they reiterate existing provisions of law. New substantive provisions are added at Section 9(a) through (f) and Section 10(a) through (d). The new language includes:
  - An explanation in the new Section 9(b) regarding how the case manager will meet participant needs through person-centered planning, which is required by a change in federal law.
  - Directions for how the Case Manager must maintain an individual case file and service documentation in the new Section 9(d).
  - The new Section 10(b) describes the elements of each individual plan of care. These provisions were not previously included in Chapter 45 and were moved to this section to centralize case management duties in one rule.
  - The new Section 10(d) includes a requirement that plans of care must be written in plain, easily understandable, language. This is a new federal requirement.
- The service definitions and qualifications found in the old Chapter 45, Sections 8 through 22 are now in Section 5(b) of the new rule, Provider Qualifications for Each Waiver Service. Furthermore:
  - Qualification requirements, which are common to all services, are consolidated in Section 5(a).
  - Items that repeat provisions of the chapter or other Medicaid rules are deleted.
  - Except for case management services, existing service qualifications are not changed.
  - Minimum qualifications and definitions are added for the following new services: Adult Day Services, Behavioral Support Services, Community Integration Services, Crisis Intervention Support, Independent Support Broker, Employment Discovery and

Customization; Independent Support Broker; Individual Habilitation Training, and Prevocational.

- Significant additional language is added to the new Section 5(b)(iii) regarding case management services. The changes are to better reflect the level of responsibility required to deliver case management services. To qualify to provide Case Management services, case managers must have a master's degree, a bachelor's degree and one year of work experience, or an associate's degree and four years of work experience. Degrees and work experience must be in one of the ten identified human service fields. Additional allowances are made for case managers certified prior to the implementation of this rule. Additionally, persons or entities seeking to provide case management services must:
  - Have policies and procedures for backups;
  - Maintain proof of competencies for each employee providing case management services; and
  - Meet conflict free requirements established to ensure that the case manager does not have a financial interest in other services provided to the participant or a financial relationship with other providers on the participant's individual plan of care.

- Chapter 45, Section 23. Standards for CARF Accredited Organizations of the current rule moved to Section 25 in the new rule.
  - Under Section 25(a) of the new rule, accreditation still applies to habilitation service providers. Accreditation now also includes providers involved in residential services, supported living, community integration, adult day services, prevocational, and supported employment services. The reason for the change is to better protect participants since accreditation is available in all of these areas.
  - Section 23(a) previously required providers to obtain accreditation within 24 months of providing qualifying services to three (3) or more participants. The new Section 25(a) adds that this requirement only applies to providers whose waiver income exceeds $125,000 per calendar year. Accreditation must now be obtained within eighteen (18) months. BHD hopes this change makes accreditation more affordable for providers. The shorter timeframe protects participants.
  - Section 25(b) of the new rule expands national accreditation to include the Commission on Quality and Leadership, CARF, or another nationally recognized accreditation entity approved by the Division. This change allows for provider choice in accrediting body.
  - Section 25(c) of the new rule maintains the same process for decertifying providers who fail to maintain the required accreditation. Unnecessary and redundant language regarding this process was removed.
  - Section 25(d) of the new rule now requires accredited providers to establish a human rights committee and establishes duties for the committee. This requirement is consistent with CARF and other accrediting entity's requirements to protect participants.
- Chapter 45, Sections 23 and 24 of the current rule both contained standards related to health, safety, emergency plans, inspections, access to food, and facility maintenance. While these standards were similar or even identical, they appeared split based upon

whether the provider was CARF accredited. Inconsistency between Sections 23 and 24 created problems in the application of these standards. Accordingly, standards for provider facilities are now consolidated in Section 13 of the new rule and apply uniformly across the state to all provider facilities. Furthermore:

- The current rule Section 24(c) regarding provider self-inspections moved to Section 13(d) of the new rule and requires all providers to annually verify that they are in compliance with the other provisions of Section 13.
- Sections 23(e) and 24(b) of the current rule require external inspections every three (3) years. The new rule, Section 13(c)(i) through (iii) requires external inspections every twenty-four (24) months.
- Sections 23(e)(iii) and 24(b)(vii) of the current rule do not allow provider services in new locations until the Division reviews the external inspection report and verifies all recommendations. The new rule, Section 13(c)(v) requires the provider to create and submit a corrective action plan rather than awaiting Division approval. Services may not be provided in a facility that does not pass inspection. Similar provisions are added at Section 13(c)(vi) for renovations, which were previously not covered. BHD hopes these changes speed up the process for opening up new locations.

- Chapter 45, Section 25, Background Check Requirements from the current rule are located in Section 14 of the new rule.
  - Section 25(c)(i) of the current rules requires a background check for all providers and provider employees. The new rule, Section 14(a), adds the coverage for certain managers, supervisors, other service providers, and persons who may have unsupervised access to participants or a participant's residence on behalf of the provider organization. This is consistent with, and clarifies, the original intent of the rule.
  - The new rule, Section 14(f), maintains all excluded offense categories listed in the current rule and adds: all felonies; misdemeanor crimes against the morals, decency, or family; misdemeanor crimes against a person; misdemeanor fraud, forgery, or identify theft; and driving under the influence for persons providing transportation services as offenses that limit a person's eligibility to provide services.
  - Section 14(g) of the new rule allows persons, who maintain clean background checks for over five years, to request that the Division grant a waiver of the criminal background check requirement.
- Chapter 45, Section 26. Provider and Provider Staff Training Requirements from the current rule are now addressed in Section 15 of the new rule. Unnecessary or redundant language was eliminated where possible. The following significant changes were made to improve provider and staff accountability to each individual participant's needs:
  - The new Section 15(b) requires provider staff to able to demonstrate competence in their ability to support participants.
  - The new Section 15(d) retains previous general training categories and adds modules for: participant choice, dignity, and respectful interactions with participants.
  - The Division is deleting current provisions found in Section 26(b) regarding participant specific training. Under the new rule, Section 15(g) and (h) requires providers to provide and document participant specific training that is unique to the

needs of the participant. Case managers must verify that the training is participant specific and provided as documented.

- Chapter 45, Section 27, Documentation Standards, from the current rule moved to Section 8 in the new rule. Several minor changes were also made to this section, including:
  - The new rule, Section 8(a), clarifies that these documentation standards apply to all medical and financial records.
  - The new rules specify that documentation must be completed prior to or contemporaneously with all claims submissions, Section 8(b).
  - The new Section 8(c) and (d) allows providers to utilize electronic documentation systems and establishes requirements. The previous rule was silent on this topic.
  - Written service documentation must now include a printed name of the person performing the service, Section 8(e)(vii).
  - The new Section 8(f) includes provisions for documenting self-directed services.
  - Section 27(d) of the current rule allows providers to bill for multiple services at a time when the participant's plan of care required it or when daily and monthly rates overlapped. Section 8(h) and (i) of the new rule deletes the rate overlap provision and specifies that a single provider employee may only provide one service at a time.
  - The new rule, Section 8(j), defines a limited allowance for skilled nursing providers to round up their unit of service. No similar provision previously existed.
- Chapter 45, Sections 28. Restraint standards from the current rule was moved to Section 18 of the new rule. The new Section 18 establishes new standards for these procedures and adds restrictive interventions to this category. Providers that have used these practices under the current rule will need to review this section carefully and implement program wide changes in order to maintain compliance. The Division hopes that these changes will reduce or eliminate the use of all forms of restriction and restraint in community service programs funded through Wyoming's Medicaid Home and Community Based Waivers, while also improving participant safety in services and allowing greater access to the community. Among the most significant changes in these regulations:
  - Providers must review the plan of care to ensure that the plan of care is not provoking behaviors or leading to restraints, new Section 18(b).
  - The use of restrictive interventions must be unanimously approved by the plan of care team, new Section 18(e).
  - Participant specific restrictive intervention protocols must be developed before restrictive interventions may be utilized, new Section 18(g).
  - Additional training is required for all provider staff who actively participate in restrictive interventions, new Section 18(j).
  - Provider organizations that use restrictive interventions with more than five participants must employ one or more persons certified in a nationally recognized behavior support curriculum, new Section 18(k).
  - Restraints, time outs, and community access restrictions are all defined as restrictive interventions, new Section 18(l). Because they are restrictive interventions, time out and community access restrictions may not be part of a positive behavior support plan.

- New documentation and new requirements for follow-up are adopted in Section 18(m).
- Case managers are required to follow up within 48 hours of all restrictive interventions, new Section 18(n).
- The Division is establishing new prohibitions and sanctions for providers use seek to seclude waiver participants, new Section 18(p).
- Additional forms of and purposes for restrictive interventions are prohibited, new Section 18(q). New prohibitions include: restraint that is contraindicated, any form of restraint that restricts a person's freedom to breathe, and supine forms of restraint.

- Chapter 45, Section 29. Positive Behavior Support Plan Standards from the current rule is now addressed in the new rule's Section 17, Positive Behavior Supports. Many of the requirements for developing and implementing the positive behavior support plan remain unchanged. Although, they have been rephrased to provide additional clarity, and emphasize the positive therapeutic nature of the plans. Rights restrictions are no longer allowed as a form of positive behavioral support, and are addressed separately in Section 4 of the new rule. Time outs and community access restrictions are also removed from this section and included as restrictive interventions in the new Section 18 as described above. These changes will focus on a positive approach to decreasing negative behaviors.
- Chapter 45, Section 30. Notification of Incident Process from the current rule is now addressed in Section 20 of the new rule. Changes include:
  - Adding citations for terms defined in statute, new Section 20(a);
  - Providing for additional non-critical event reporting to the Division in new Section 20(b), which promotes greater provider accountability before serious events occur; and
  - Adding specificity to the times for filing reports and providing follow-up information to the Division, new Sections 20(d) and (f).
- Chapter 45, Section 31. Complaint Process from the current rule is now addressed in Section 21 of the new rule. The complaint process in the current rule distinguishes between CARF accredited providers and Non-CARF accredited providers. This distinction is eliminated in the new rule to promote consistency among providers.
- Chapter 45, Section 32. Transition Process from the current rule moved to Section 22 in the new rule. The new rule also matches current policy, practices, and expectations, and:
  - Clarifies that participants may chose to change providers at any time for any reason, new Section 22(a).
  - Specifically requires case managers to modify the participant's plan of care as part of the transition process, new Section 22(d)(v).
  - Allows participants to choose from all available residential service providers any time the participant is required to move residential settings, new Section 22(f). This is consistent with new federal guidance on freedom of choice.
- Chapter 45, Section 33. Funds of Participants in the current rule is now addressed in the new rule's Section 24, Participation Funds and Personal Property. The new Section 24(c) is an addition, which is included to prohibit providers from misappropriating participant funds.

- Chapter 45, Section 34. Mortality Review Committee of the current rule is now addressed in Section 26 of the new rule. Subsections 34(c)(i) and (ii) of the current rule are deleted because they were deemed unnecessary.
- Chapter 45, Section 35. Initial Provider Certification of the current rule is now addressed in Section 27 of the new rule.
    - The Division removed the list of applicant criteria currently in Section 35(a). Under the new Section 27(a) applicants submit evidence to show that they meet all qualifications for each service that the applicant is seeking to provide.
    - The Division deleted the current Sections 37(b) through 37(d). These procedures for holding provider applications, assigning provider numbers, and providing telephone consultation are internal procedures that do not need to be provided in rule.
    - The new Section 27(b) adds language that states that the Division will only certify one provider per physical location to eliminate confusion and clearly delineate who is providing which services.
    - The length of an initial certification currently found in Section 37(e) moved to Section 28(b).
    - The current Section 37(f) moves up to become the new Section 27(c). The provision retains the former prohibition against certifying providers as new provider entities if the person or entity has an open corrective action plan with the Division. A new provision adds that providers may not be certified if they are the subject of an open case with the Medicaid Fraud Control Unit of the Wyoming Attorney General's Office.
    - The new Section 27(h) allows the Division to disqualified providers from individual services if they no longer meet certification criteria.
- Chapter 45, Section 36. Recertification of Providers of the current rule is now split between the Section 28, Recertification of Providers and Section 29, Corrective Action Plan Requirements in the new rule.
    - Significant changes for the new Section 28 include:
        - The current Section 36(c)(i) is deleted; this provision allowed certification for up to two years. The new Section 28(b)(i) through (b)(iii), allows providers to be certified for one, two, or three years based on the provider's service category. This change was made to allow the Division to focus on providers providing higher intensity services, such as residential habilitation, and less on providers who have other licensing boards that provide oversight, such as therapists.
        - The new Section 28(f)(iii) explicitly allows the Division to deny certification.
    - The new Section 29 repeals previous language regarding quality improvement plans in favor of the term corrective action plans. This was done to promote consistency among the rules. The following provisions are in addition to the procedures in the current rule:
        - The Division will seek the cooperation of all providers in meeting the standards in the Wyoming Medicaid rules under New Section 29(a).
        - The new Section 29(b) allows the Division and providers to resolve any suspected non-compliance through a corrective action plan.
        - New Sections 29(c) and 29(d) provide new requirements for acceptable corrective action plans.

    - Under the new rule, Section 29(h) Providers have the primary responsibility for implementing and overseeing corrective action plans. However, the Division may also complete follow-up investigations and review corrective action plan completion under the new Section 29(i).
- Chapter 45, Sections 37, Sanctions, subsections (a) through (c) of the current rule are deleted because they restated the statute. The new rule, Section 30(a) reminds providers that sanctions are covered by Chapter 16 of the Medicaid Rules. Minor modifications were made to the timelines for participants to transition to covered services when providers are terminated. These are found in Section 30(c) of the new rule. These changes do not change procedures or policies, but clarify where confusion has occurred.
- Chapter 45, Section 48. Interpretation of Chapter moved to Section 32 of the new rule.
- Chapter 45, Section 49, Superseding Effect, of the current rule moved to Section 33 of the new rule and is updated to match more recent Medicaid rule promulgations.
- Chapter 45, Section 50, Severability, of the current rule moved to Section 34 of the new rule.

****** The following are sections or portions of sections that are new and not part of the current Chapter 45.***

- Section 4, Rights of Participants Receiving Services, establishes narrow limitations on the ways that Wyoming Medicaid Home and Community Based Waiver service providers may restrict a participant's state and federally recognized rights and liberties. Many of the provisions of this section will be familiar to providers, but the language was expanded to increase protections for participants.
- Section 6, Provider Agency Standards, establishes requirements for providers to ensure individual participant rights are not violated, requires quality improvement activities within provider organizations, and requires providers to adopt policies and procedures to demonstrate compliance with the provisions of this Chapter. This addition was made to articulate basic provider responsibilities and standards when serving waiver participants, which are articulated in the new federal rule and in federal guidance.
- Section 7, Provider Recordkeeping and Data Collection, outlines provider requirements to maintain data, statistics, schedules, reports, and other information.
- Section 11, Rate Reimbursement Requirements. As required by Wyoming Statutes § 42-4-120(g), this section establishes additional procedures that the Division will follow when reviewing its cost based reimbursement system.
- Section 12, Service and setting requirements for social security recipients, requires all residential service providers to supply limited information to the Division about their service settings. This information is collected so that the State can provide federal reports under Section 1616(e) of the Social Security Act.
- The new Section 13 provides additional regulations aimed at promoting a more home-like environment for all persons served on the Wyoming Medicaid Home and Community Based Waivers affected by this rule.
- Section 19, Psychoactive Medication Usage Standards, replaces and greatly expands upon community recognized practices for the use of psychoactive medications for the populations served by programs impacted by this rule. These changes support and

augment policy recommendations and changes made by the Division after consultation with community providers in recent years.

- Section 31, Relative Providers is new language which defines the ways that relatives of program participants may provide services to those participants as allowed by Wyoming Statute § 42-4-102.

Chapter 46

Rules and Regulations for Medicaid Supports and Comprehensive Waivers

Statutory authority for the adoption of Chapter 46, Rules and Regulations for Medicaid Supports and Comprehensive Waivers, is in Wyoming Statute §§ 9-2-102, 42-4-104, 42-4-120, the 2013 Wyoming Session Laws page no. 322 through 325, and the Wyoming Administrative Procedures Act found at §§ 16-3-101 through 16-3-115.

Chapter 46 was developed to establish the Supports and Comprehensive Waiver Rule using standards and guidelines from Centers for Medicare and Medicaid Services (CMS). Chapter 46 establishes a person-centered approach to determine participant support needs in the Individual Plan of Care and assigns an individual budget amount. The essential components of Chapter 46 include; development of community connections, increased independence, natural supports, self-direction, and employment opportunities. The services offered on the Supports Waiver are not as extensive as the services offered on the Comprehensive Waiver.

In March 2013, the Wyoming Legislature passed Senate Enrolled Act 82, a law requiring the Wyoming Department of Health, Behavioral Health Division (BHD) to develop two new waivers, the Supports Waiver and the Comprehensive Waiver. The new law required BHD to "optimize the services provided to current clients, and to extend appropriate services to persons currently on a waiting list for waiver services within the current budget." This rule establishes these programs and implements these requirements.

All Adult or Child Developmental Disabilities Waiver participants currently receiving services will be moved to the new Comprehensive Waiver, unless the participant chooses the Supports Waiver. The Supports Waiver and the Comprehensive Waiver became effective April 1, 2014. After all current wavier participants are transitioned to the new waivers, Chapters 41 and 42 (the old waiver rules) will be repealed.

Chapter 46 also includes the language for Conflict Free Case Management and the situations in which conflicts must be avoided. These changes are a result of the new federal regulations in 42 CFR 441.301 which requires a plan of care to be developed using a case manager that is free from conflicts of interest.

Rules Reduction

Consistent with the Governor's directive to reduce rules, the Department of Health removed unnecessary redundancy between these chapters, other existing Medicaid rules, and Wyoming statutes. The Department of Health also eliminated provisions where lawmaking is not necessary in favor of providing better regulatory guidance. Minor revisions were also applied to these chapters to improve ease of understanding, and general readability throughout.

We are only introducing one chapter of new rules for the two new waiver programs. We are decreasing the rules specific to the Adult DD, Child DD, and ABI waivers by 3 chapters, 52 pages, and 13047 words. This is a 64% change in total content for the Adult DD, Child DD and ABI waivers.